

New Leaf Plastic and Reconstructive Surgery

FINANCIAL POLICY

Patient: _____ SSN: _____ Date: _____

Thank you for choosing Clinical Care Associates as your healthcare provider. This office is committed to your health and successful treatment. Please understand that payment of your services is considered part of your treatment. We ask that you please read the following FINANCIAL POLICY and sign this form prior to any treatment.

ALL COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME THE SERVICE IS RENDERED. IF OTHER ARRANGEMENTS NEED TO BE MADE, PLEASE SPEAK WITH THE RECEPTIONIST PRIOR TO YOUR VISIT. ALL COSMETIC FEES ARE DUE AT THE TIME OF SERVICE. THERE IS ALSO A \$500 SCHEDULING FEE DUE FOR SURGICAL SERVICES WHICH IS NONREFUNDABLE WITH CANCELLATION.

WE ACCEPT CASH, CHECK, VISA, AND MASTERCARD.

INSURANCE

We do accept assignment on your insurance benefits. We must have your insurance information to do any insurance billing. In event that your insurance company does not pay, we reserve the right to transfer balances to your responsibility. We will be happy to assist you by providing you with claim forms and an explanation of benefits from your primary insurance after your balance with us is satisfied.

Please be aware that some of the services provided may not be considered reasonable and necessary under your health plan.

All copays and deductibles are due at the time of treatment unless prior billing arrangements have been made. If your insurance requires a referral, we request that you bring it with you at the time of your visit.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans.

This assignment will remain in effect until revoked by me in writing. A copy of the Assignment is to be considered as valid as an original.

I understand that I am financially responsible for all charges. I hereby authorize Clinical Care Associates- New Leaf Plastic and Reconstructive Surgery to release all information necessary to secure payment.

Signature Patient/Legal Guardian: _____

Patient: _____ SSN: _____ Date: _____

MEDICARE GUIDELINES

I authorized any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I permit a copy of this request for payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature Patient/Legal Guardian: _____

USUAL AND CUSTOMARY RATES

Clinical Care Associates is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT AND MINOR PATIENTS

Adult patients are responsible for payment at time of service. Minor patients must be accompanied by a parent or legal guardian who is responsible for the minor. Payment for services provided to minors is due at time of service.

MISSED APPOINTMENTS

Unless canceled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of 50% of a normal office visit.

FORMS COMPLETION

There will be a \$15.00 charge for items for which the physician and/or staff are required to complete including by not limited to the following items:

- a. Letter of Medical Necessity
- b. Family Medical Leave Forms
- c. Disability Forms
- d. Application for handicapped parking permits and or license
- e. Prior authorization of medications through an insurance company

Thank you for understanding our FINANCIAL POLICY. Please let us know if you have any questions or concerns.

I have read the FINANCIAL POLICY. I understand and agree to this policy.

Signature Patient/Legal Guardian: _____